

# Dental Quality Assurance Commission Newsletter March 2016

## Inside this issue

Hot Topic– Dental Ethics and Ethical Behavior	1
Patient Records-Who knew?	1
Reducing Risk From Prescribing of Opioids	2
Quack Files	3
Patient Referral Incentives	5
Dr. DQAC	7
Infamous or Famous	7
Washington Physician Health Program	9
Accessing Provider Discipline	10

## Commission Members

Charles Hall, D.D.S., Chair  
Colleen Madden,  
Public Member, Vice-Chair  
Todd Cooper, D.D.S.  
Paul W. Bryan, D.M.D.,  
LouAnn Mercier, D.D.S.  
Robert Shaw, D.M.D.  
John Carbery, D.M.D.  
James Henderson,  
Public Member  
Hyun Jung Song, D.D.S.  
Kara Baza, EFDA  
Bree Kramer, EFDA  
Karim Alibhai, D.M.D.  
John R. Liu, D.D.S.  
Kunal Walia, D.D.S.  
Aaron Stevens, D.M.D.

## Hot Topic

### Dental Ethics and Ethical Behavior

In this issue, the Dental Quality Assurance Commission will focus on ethical obligation.

Health care practitioners embrace many ethical codes, "Do No Harm" being the most common. Others are specifically developed for the dental professional. The American Dental Association (ADA) Principles of Ethics are national goals of the profession. They issue five fundamental principles: patient autonomy, non-maleficence, beneficence, justice and veracity. The ADA's Code of Professional Conduct provides specific types of conduct that may be required or prohibited.

- Patient autonomy – self governance
- Non-maleficence – do no harm
- Beneficence – do good
- Justice - fairness
- Veracity - truthfulness

[continued on page 4](#)

## Patient Records—Who knew?

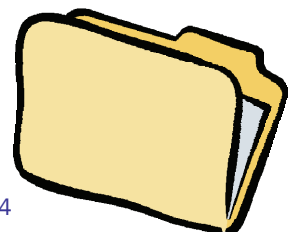
A health care provider is required to securely maintain a patient record for a specified number of years as indicated in profession-specific laws. As a dentist, you are currently required to keep a patient record for five years, [WAC 246-817-310](#). Soon you will be required to keep a patient record for six years.

A dentist has the ethical duty to provide a copy of a patient record as it may benefit the future treatment of a patient.

Under state law, chapter [RCW 70.02](#), a health care provider must respond to a request and release a record when a patient requests. Every health care provider must respond to a written request from a patient no later than 15 working days after receiving the request. The health care provider can charge a reasonable fee for a copy of the patient record.

The reasonable fee is defined in [WAC 246-08-400](#). This rule changes every two years. Check it

[continued on page 4](#)



## Recommendations for Reducing Risk From Prescribing of Opioids for Dental Pain

*Submitted by Gary Garrety, PMP Operations Manager, Kathy Lofy, MD, Washington State Health Officer, and Gary Franklin, MD, MPH, for the AMDG and the Bree Collaborative*

*“Dentists cannot assume that their prescribing of opioids does not affect the opioid abuse problem in the United States.” – “Prevention of Prescription Opioid Abuse” The Journal of the American Dental Association, July 2011 Vol 142, Article Abstract.*

In the state of Washington and across the country, the battle against opioid abuse continues. Accidental drug overdoses kill more people each year in our state than traffic accidents. They have been the leading cause of accidental death in Washington since 2008.

Opioids are powerful drugs that can be useful to manage pain, but inappropriate use can lead to significant harm – including addiction and death. Washington has worked to develop effective tools to address the opioid crisis in our state.

First released in 2007, the [Interagency Guideline on Prescribing Opioids for Pain](#) is a product of the Washington State [Agency Medical Directors’ Group](#) (AMDG), in collaboration with pain and substance abuse experts, primary care practitioners, and interested members of the public. The guideline is now in its third edition. The 2015 guideline contains new and modified sections, including a section on managing acute pain, and outlines a more comprehensive and balanced approach to pain management. The guideline supplements the Washington State Department of Health’s [Pain Management Rules](#).

Washington’s [Prescription Monitoring Program](#) (PMP), also known as Prescription Review, came online for prescribers in early 2012. The program collects information on dispensing pain medications and other potentially dangerous or addictive controlled medicines in our state. Prescribers can verify the controlled substance medication history of their patients using the PMP. Prescribers can [create a PMP account](#) and access the program database through a secure web portal where the system can be queried directly or licensed staff can be selected as delegate(s) to query the system on behalf of the prescriber. Quicker and more convenient access to PMP data can be established by connecting the Electronic Healthcare Records (EHR) system to the PMP via the state [Health Information Exchange](#) (HIE). This connection will also help meet [Meaningful Use](#) requirements as a [Specialized Registry](#). Technical assistance to establish a connection between the HIE and your EHR is available from [OneHealthPort](#).

These and other statewide efforts have already led to a 37 percent decrease in prescription opioid-related deaths since 2008. Though we’ve been fortunate to see a continued decline in prescription opioid overdose deaths, overdose from prescription opioids continues to claim more than 300 Washington lives annually. There has also been a rise in the number of deaths in Washington because of heroin overdose in the past few years. Evidence suggests that for the majority of these heroin users, their introduction to opioid drugs was a prescription opioid. Data from the Centers for Disease Control (CDC) reveal three out of four people who used heroin

[continued on page 6](#)

## Reader Input

The commission is looking for reader input. If you want to read about something specific, [please let us know](#).



# Quack Files—It Wasn't Me!

## Episode Three

Provided by Paul Bryan, D.M.D.

Keani Gumataotao stood across the counter from the pharmacist as he told her of his suspicions. Keani was a Department of Health investigator looking into the prescription abuse case from Dr. Vetana's office. The pharmacist named Don was gushing with information being a victim of Keani's charm and alluring Guamanian accent.

"Oh, I knew something was up the first time I saw that sketchy guy walk in the door," he said, his head nodding up and down. "Then he handed me a scrip for Tramadol." He pursed his lips and went silent, basking in the moment. "He did it three times and I just knew. That's when I sent in the complaint."

He went on to describe Anna's boyfriend, including a tattoo of a killer whale just below his navel rising up from his belt buckle. Keani's eyes widened and Don added, "Oh, he always wears a little half-T showing off his abs." He rolled his eyes and added, "They're not that great."

Keani smiled and asked, "Why do you suppose Dr. Vetana wrote the prescription?"

Don was taken aback, "No, no, it couldn't be Dr. Kim. It's got to be one of those assistants down there. Dr. Kim, that's what he makes me call him—he's so funny, he's always in here telling me about his surgeries and how grateful he is for our help in keeping his patients out of pain."

He smiled wistfully to himself, then got serious and stared right at Keani. "Dr. Kim may write more Tram and Oxy scrips that anyone I know, but they are all legitimate. He's the busiest dental surgeon in the whole state. He does all of the wisdom teeth for teen shelters up and down the

I-5 corridor and," putting his finger to his lips he whispered, "I think he does it all at cost." "If the kids live in a shelter, who picks up the medication?" Keani asked.

"Always the same lady," Don chimed, "I think she works for the state too." Keani thanked Don for his statement, but, as she turned to go, she asked one more question, "Say, have you ever been to his office?"

"Oh, my no," Don responded, "he's far too busy to have me stop by. I only see him here and at the casino." He smiled and added proudly, "I'm just glad I can help those kids by discounting the meds."

She smiled back. "Thank you," she said, and left the store wondering why she never saw any teenagers at Dr. "Kim's" office. In fact, she wondered why she rarely saw any patients at the office.

Keani made a few more visits to the dental office, some official, others not. She completed her report and submitted it for Commissioner Johanason's review.

Normally Meghan would wait for the regular DQAC meeting to present her findings, but this case was a little different. A conference call was conducted with a room full of staff members and attorneys at the Department of Health, and all five disciplinary panel members. The call lasted 20 minutes.

The DEA was invited to the party. It learned that Anna's boyfriend had met her at the office one evening, after hours, while she was finishing up sterilization,

### Missed Episode 1 or 2?

[Access it on our  
webpage.](#)

### Washington Recovery and Monitoring Program

WRAMP is a monitoring program for health care professionals whose practice may be impaired by substance abuse. Visit their [webpage](#) for more info.

### Prescription Monitoring Program

You can get more information on PMP online at [www.doh.wa.gov/hsqa/PMP](http://www.doh.wa.gov/hsqa/PMP). Contact program director Chris Baumgartner, 360-236-4806, for more information.

continued on page 10

## Patient Records—Who Knew?

continued from page 1

often. A health care provider cannot withhold a copy for non-payment of services or an overdue bill. Withholding or denying a patient a copy of the record is allowed only for reasons listed in [RCW 70.02.090](#).

The Dental Quality Assurance Commission receives routine inquiries about record releases. Don't get caught ignoring or denying a request for an unauthorized reason. It's unethical and a violation of law.

The commission has recently approved modifications to WAC 246-817-310. To receive important information about rule changes by email, join our [Listserv](#).

## Hot Topic — Dental Ethics and Ethical Behavior

continued from page 1

Each principle and associated code is detailed in the ADA's published document, Principles of Ethics and Code of Professional Conduct.

As a non-member of the ADA, a dentist may not be required to follow the ADA code, but as a Washington State credentialed health care provider, non-ethical decisions may result in unprofessional conduct that can be a violation of state law, chapter 18.130 RCW.

Ethical obligation may outweigh a dentist's legal requirement. A dentist should follow high ethical standards that consider the well-being of the patient.

The Dental Quality Assurance Commission encourages all dental team members to practice ethical behavior. It benefits you, your team, and your patients.

**Patient or Revenue Stream?**

Ethical treatment of patients may come down to one easy question:

**Are you healing patients or upselling customers?**

Think about it.

## Dental Quality Assurance Commission

[The commission](#) is made up of 12 dentists, two expanded function dental auxiliaries, and two public members. Members attend regular meetings, scheduled for one day on a Friday every six to eight weeks. Members are appointed by the governor for four-year terms.

- Want to be a full member? Get the [Governor's application](#) here.
- Want to be a pro tem (limited participation) member? Get the [department's application](#) here.

[Jennifer Santiago](#) is available to answer all your questions about being a member.

## Patient Referral Incentives

Provided by Dr. Rod Wentworth

In the past few years, there has been a lot of talk about patient referral programs. There seems to be a lot of confusion as to how it can be done ethically. I have been asked if a dentist can promote new patient referrals by offering current patients such things as gift cards or account credits for each new patient they refer. So, how can we ethically reward our patients for their kind referrals?

Let's look at how our *ADA Principles of Ethics and Code of Professional Conduct* addresses it. Section **5.F.4. REFERRAL SERVICES** speaks to this topic:

A dentist is allowed to pay for any advertising permitted by the *Code*, but is generally not permitted to make payments to another person or entity for the referral of a patient for professional services.

In addition, Section **4.E. REBATES AND SPLIT FEES** notes,

Dentists shall not accept or tender "rebates" or "split fees."

A split fee occurs when you offer to return a portion of the fee you collect to the referral source. A rebate is essentially the same thing. A discount on future fees, credit on their accounts, or cash back to the referring parties would also apply.

The following Washington state laws also deal with rebates and split fees:

RCW [19.68.010](#): It shall be unlawful for any person, firm, corporation or association ... to pay, or offer to

pay ... to any person licensed by the state of Washington to engage in the practice of ... dentistry, ... and it shall be unlawful for such person to request, receive or allow, directly or indirectly, a rebate, refund, commission, unearned discount or profit by means of a credit or other valuable consideration in connection with the referral of patients to any person, firm, corporation or association.... Any person violating this section is guilty of a misdemeanor.

RCW [19.68.020](#): The acceptance directly or indirectly by any person so licensed of any rebate, refund, commission, unearned discount, or profit by means of a credit or other valuable consideration whether in the form of money or otherwise, as compensation for referring patients to any person, firm, corporation or association as set forth in RCW [19.68.030](#), constitutes unprofessional conduct.

RCW [19.68.030](#): The license of any person so licensed may be revoked or suspended if he or she has directly or indirectly requested, received, or participated in the division, transference, assignment, rebate, splitting, or refunding of a fee for, or has directly or indirectly requested, received, or profited by means of a credit or other valuable consideration as a commission, discount, or gratuity in connection with the furnishing of medical, surgical, or dental care...

Now that we have the legal and ethical guidance for how to proceed, it should be noted that there is no ethical prohibition on rewarding a patient for a referral. A thank-you note with a nominal gift card would not, in itself, violate our Code. However, problems could arise if you were to offer a reward or credit up front to anyone who refers a new

[continued on page 8](#)



It is the purpose of the commission established in [RCW 18.32.0351](#) to regulate the competency and quality of professional healthcare providers under its jurisdiction by establishing, monitoring, and enforcing qualifications for licensure, continuing education, consistent standards of practice, continuing competency mechanisms, and discipline.

[Access your dental chapter 246-817 WAC rules here.](#)



## Recommendations for Reducing Risks

continued from page 2

in the past year misused prescription opioids first; and seven out of 10 people who used heroin in the past year also misused prescription opioids in the past year.

When managing dental pain, using the PMP to review your patients' controlled substance history and following recommendations made in the [AMDG Guideline](#) can help ensure the safety of your patients and help to mitigate prescribing liability for you and your practice.

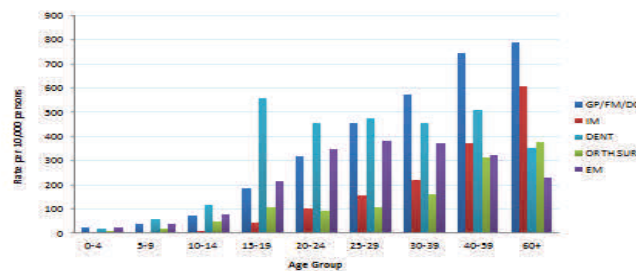
The Washington State Legislature established the [Dr. Robert Bree Collaborative](#) so that public and private health care purchasers, clinicians, hospitals, health plans, and organizations dedicated to quality improvement would have the opportunity to identify ways to improve health care quality, outcomes, and affordability. The Bree Collaborative has identified our state's opioid epidemic as an important issue to address, and has reviewed, adopted and is working to implement the AMDG prescribing guidelines. By implementing the guidelines in public and private health care systems the collaborative hopes to reduce the harm opioids cause in our state through improved prescribing practices.

The Bree Collaborative, the AMDG, and the PMP would like to partner with the Dental Quality Assurance Commission, the Washington State Dental Association, the UW Dental School, and other interested stakeholders to accomplish the following goals that are consistent with the AMDG Guidelines:

1. Prescribe opioids for dental pain only after complex dental procedures and at the lowest dose and duration. Three or fewer days should be sufficient to control pain after a dental procedure. Limiting the dosage and duration of a prescription is particularly important in adolescents since use of prescription opioids in adolescents is associated with an increased risk of non-medical abuse of opioids in young adulthood.

Rationale: Dentists are the most common prescribers of opioids for people 20 years old or younger (see graph below from the National Institute on Drug Abuse). A recent study using national data showed that receipt of even one prescription for opioids in high school is associated with a 33 percent increased risk of non-medical abuse of opioids for people between the ages of 18 and 23 years (Mieche et al., Pediatrics, 2015). In addition, the vast majority of the recent increase in heroin deaths has occurred in the 18–25 year age group (Compton et al., N Engl J Med, 2016). This suggests that reducing the prescribing of opioids for this age group to the least amount necessary for effective treatment may substantially reduce future misuse and unintended severe consequences of unused medication.

**Dentists and Emergency Medicine Physicians were the main prescribers for patients 5-29 years of age**  
5.5 million prescriptions were prescribed to children and teens (19 years and under) in 2009



Source: IMS Vector® One National, TPT 06-09-10 Opioids Rate 2009

2. Check the Washington state PMP with any request for a repeat prescription for an opioid.

Rationale: The Washington AMDG Guidelines suggest checking the Washington PMP with any first prescription for an opioid,

before embarking on chronic opioid use (more than 90 days), and periodically during chronic opioid use. The PMP would assist a dental prescriber in determining if the patient is receiving controlled substances from multiple providers or is at high risk for adverse effects of opioids (e.g., doses more than 120 mg per day morphine equivalent dose, concurrent benzodiazepine or sedative hypnotic use).

In the interest of partnering efforts, the Bree Collaborative invites the Dental Quality Assurance Commission to endorse a few clinical or academic dental leaders who could join and contribute to the efforts of the collaborative. Additionally, we hope the Commission will review and endorse the above recommendations for the practice of dentistry in Washington.

## Dear Dr. DQAC

**Dear Dr. DQAC,**

I was at a conference a few years ago and the class I was taking was not what I'd hoped it to be, so after an hour I left and sat in on another class. It was a great class but I was in the class for only one hour of the two-hour class. At the end of the class I was handed a continuing education certificate for the full two hours.

I received two hours of CE but the certificate doesn't reflect that it was on two different topics. I'm tempted to just turn in the form as I really did receive two hours of CE but there is a moral question in this mess. Ugh. And this is the year I have only 21 CE hours, too.

Dr. On the Edge

**Dear Dr. Edge,**

Each year we may audit up to 25 percent of the dentists in Washington for their CE credits. If your documentation has the appropriate dispersal, then your documentation will pass our initial screening without an in-depth review by a commission panel. Ethically, you have completed the requirements. Technically, the paperwork has some minor inaccuracies. You may make a signed notation describing the hour from the other class correcting the paperwork issue and the commission will

take that into account. Here is a helpful website for other CE questions.

<http://www.doh.wa.gov/LicensesPermitsandCertificates/ProfessionsNewReneworUpdate/Dentist/ContinuingEducation>

**Dear Dr. DQAC,**

When is it OK to lie to your patients?

I have patients who come into my office wearing orange on Blue Friday. My entire staff is wearing Seahawks blue. I smile and say, "Go Broncos." I know my staff will punish me later by stirring my coffee with their fingers, but it puts the patient at ease and makes the appointment more bearable.

Am I guilty of unprofessional conduct under the "moral turpitude" definition?

Dr. P. Manning

**Dear Dr. Manning (really?)**

My daughter lives in Denver. I feel your pain.

continued on page 8

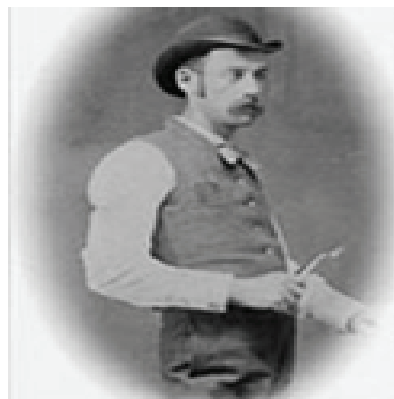


### Be Informed

To receive updates to rules, join our [Listserv](#) (interested parties email list). Please contact [Jennifer Santiago](#) for copies of proposed rules or to provide any comment on any rule changes.

## Infamous or Famous

**John Henry "Doc" Holliday:** Did you know that before Doc Holliday was known as the infamous friend of Wyatt Earp and one of the gunslingers shooting it up at the O.K. Corral, Holliday was actually a dentist with a successful little practice in Atlanta. Holliday later contracted tuberculosis and left his practice to move out West, where the rest is, well...history.



Know of a famous dentist?

[Let us know](#)

## Dear Dr. DQAC

continued from page 7

Does your affirmation of the Broncos reduce your patient's pain? Is the wellbeing of the patient your only concern? If the answer is "yes" to both questions, then you have a pretty good start at defending your position.

Health care providers have used the "placebo" effect with success. There are dentists who recommend one toothpaste or one brush with no scientific evidence, but because of their emphasis and enthusiasm the patient is more compliant in the area of oral hygiene and their disease is reduced.

Of course, recommending to every patient a \$50 tube of toothpaste with the same formula as a \$3 tube of generic leaves the realm of placebo and enters the arena of scamming for profit.

Drs. Lichenberg, Heresco-Levy and Nitzan published an article in the Journal of Medical Ethics suggesting some guidelines for the use of placebos in health care. (*J Med Ethics* 2004;30:551-554 doi:10.1136/jme.2002.002832)

- The intentions of the physician must be benevolent: her only concern the wellbeing of the patient. No economical, professional, or emotional interest should interfere with her decision.
- The placebo, when offered, must be given in

the spirit of assuaging the patient's suffering, and not merely mollifying him, silencing him, or otherwise failing to address his distress.



- When proven ineffective the placebo should be immediately withdrawn. In these circumstances, not only is the placebo useless, but it also undermines the subsequent effectiveness of medication by undoing the patient's conditioned response and expectation of being helped.
- The placebo cannot be given in place of another medication that the physician reasonably expects to be more effective. Administration of placebo should be considered when a patient is refractory to standard treatment, suffers from its side effects, or is in a situation where standard treatment does not exist.
- The physician should not hesitate to respond honestly when asked about the nature and anticipated effects of the placebo treatment he is offering.
- If the patient is helped by the placebo, discontinuing the placebo, in absence of a more effective treatment, would be unethical.

Share your comments on this topic [here](#).

## Patient Referral Incentives

continued from page 5

patient. An example would be a sign in your office or on your Facebook site offering \$100 for each new patient people send your way. Another example might be a contest with a trip to Hawaii for the person who refers the most new patients. The difference between these examples and the simple thank-you is that the thank-you is a spontaneous gesture, not contingent on the referral; whereas, the others

involve an upfront offer with the intent to exchange patient referrals for a reward. From a legal perspective, a thank-you gift of a large amount might be construed as a rebate; so, consultation with your legal adviser would be prudent if you have any concerns.

For more in-depth information on questions like this, an ethics panel discussion will be held at the Pacific Northwest Dental Conference in Bellevue, June 17, 2016.



## Washington Physician Health Program

Provided by Dr. Meredith

### Dentist “Impairment”: Who do I call? When do I call? Why do I call?

#### Q: What is impairment?

A: Impairment is not a disease, but a functional state. Various disease and physical states can cause brief or sustained impairment in one’s ability to practice dentistry safely. Examples of such physical states include severe sleep deprivation or delirium from an infectious illness or metabolic illness such as unstable diabetes. Untreated addiction, severe depression or a severe bipolar mood state can cause more prolonged impairment and recurrent unacceptable risks to patient safety.

#### Q: How common is impairment?

A: No one knows the true prevalence of provider impairment, although we have some ideas of the prevalence of various behavioral states that can cause impairment if left untreated. Estimates suggest that 1 percent of health care providers may fall into the category of impairment at some point in the course of a year.

While we know that roughly 10 percent of males in U.S. society will meet the diagnostic criteria for a severe alcohol use disorder at some point in their lifetime, we know little about dentists because of the paucity of research in this group. Recent studies in physicians indicate that 13 percent of male physicians and 21 percent of female physicians met criteria for alcohol use disorder of at least mild intensity in the past year, although it is not clear how well this data extrapolates to dentists.

In regard to dependence or abuse of drugs other than alcohol or nicotine in the past year, descriptive data from the ADA suggests dentists have much higher rates of addiction problems with opioids and nitrous oxide than does the general public.

Bipolar mood disorder is very treatable, but, along with major depressive disorder and some severe anxiety disorders, it can cause functional impairment in a dentist’s sustained ability to practice dentistry safely. Bipolar mood disorder strikes 1-3 percent of our population in the US, while major depressive disorder will affect roughly 15-20 percent of us at some point in our lifetime, and is more frequent in females. There is no evi-

dence suggesting that these conditions are any less prevalent in dentists than they would be in other segments of society.

#### Q: Do I really have to call someone if I am worried about a colleague who may be impaired?

A: Per language in the Washington Administrative Code (WAC 246-16-235), if you hold a clinical license through the Department of Health and you have knowledge “that another license holder may not be able to practice his or her profession with reasonable skill and safety due to a mental or physical condition,” *you are legally and ethically obligated* to make a report for the safety of your colleague, and for the safety of the patients that person treats.

#### Q: Whom do I call, if I am worried that a colleague is impaired?

A: If your colleague is a dentist you can fulfill your obligation by calling one of two agencies. You can call the Dental Quality Assurance Commission (DQAC) or you can make a report to the Washington Physicians Health Program (WPHP) at 1-800-552-7236. Someone at WPHP is available to take your call 24 hours per day, 365 days per year.

#### Q: What happens if I make a report with DQAC?

A: The DQAC may open an investigation of your colleague for “unprofessional conduct” for practicing dentistry while potentially impaired because of an untreated or undertreated illness. For unavoidable reasons, this has a significant likelihood of resulting in disciplinary sanctions for your colleague if the allegations can be substantiated. (This is because, in part, of the limited array of tools available to the DQAC in protecting the public from substandard dental care). There is also a high likelihood that the DQAC will have empathic concern for the well-being of your colleague and will strongly encourage your colleague to self-refer to WPHP for immediate clinical help.

#### Q: What happens if I make a report to WPHP instead of DQAC?

A: You have fulfilled your legal obligation to make a report. WPHP now has an obligation to assess your colleague as soon as possible to rule out impairment, or to arrange for adequate treatment if WPHP rules in impairment. For patient safety reasons, your colleague will

[continued on page 11](#)

## Quack Files

continued from page 3

Access dentistry  
laws here

[RCW 18.32](#)  
[WAC 246-817](#)  
[RCW 18.260](#)  
[RCW 18.350](#)  
[RCW 18.130](#)  
[WAC 246-12](#)  
[WAC 246-16](#)  
[RCW 70.02](#)

and helped himself to a prescription pad. When Anna was asked about the pads, she knew what had happened and was furious. She retrieved the pads and dropped him like a hot potato, but not before he had met Don at the pharmacy.

The DQAC chastened Anna and had her evaluated by WRAMP, where she was cleared of drug use. This and her clean record were sufficient for the DQAC and she is now, several years later, an EFDA and clinic director for a clinic assisting homeless teens.

Anna's boyfriend was never seen again.

It was discovered that Dr. Vetana was quite an experienced casino customer

in both beverages and gaming. He got way over his head and while under the influence revealed his problems to a nice lady at the casino who proffered a solution: Develop a relationship and sympathy from a local pharmacist, create a vast array of fictitious surgery patients in desperate need, and she would be the principal caregiver picking up the prescriptions and distributing them at a much higher street value. Tramadol is currently \$50 per tablet.

Splitting the profits allowed the dentist to stay above water while using the office to launder the ill-gotten gains.

License suspended. He won't be using it anyway.

## Accessing Health Care Provider Discipline Or Verifying a License

You can find  
ethics courses  
online by  
searching key  
words "dental  
ethics"

Have you ever wondered if a potential employee or any other medical professional has come under discipline from the Department of Health? Do you need to know if your license is active or if a potential employee has the appropriate credential?

The Department of Health webpage provides a provider credential search that allows you to view a health care provider's credential status and any disciplinary actions.

You can access the [Provider Credential Search](#) on the Department of Health website.

On this page you can search any health care practitioner in Washington. You will be able to see what type of credential the provider holds and the status of the credential. If the provider has been disciplined, you will see **Yes** under the Enforcement Action column. You can then click on the provider's credential number and the disciplinary documents will be available for viewing.



## Washington Physician Health Program

continued from page 9

have a reasonable, but rather limited, time frame in which to respond and comply with WPHP's clinical evaluation. The practitioner may very well have to take extended medical leave if truly impaired, and complete sufficient treatment before returning to work with active WPHP monitoring in place. If the practitioner is non-compliant with this process, WPHP has a legal obligation to then make a report to the DQAC as soon as would be appropriate.

By making your report to WPHP, you have fulfilled your legal and ethical reporting requirement. WPHP then assumes any reporting requirements to DQAC should your colleague not comply. You have given your colleague a chance to receive confidential help without being identified to the DQAC and facing the risk of disciplinary action for trying to practice while impaired by illness.

**Q: Once I've made a report to WPHP, under what circumstances does WPHP report my colleague to the DQAC?**

A: If WPHP is significantly concerned that your colleague is impaired and your colleague will not follow redirection to take medical leave from work and complete necessary evaluation and/or treatment, WPHP will notify the DQAC of your colleague's non-compliance and the risks this behavior poses to public safety. In this rare scenario, there is a high likelihood this will result in significant and swift disciplinary action from the DQAC. The risk of this contingency serves as an effective motivator for providers who are impaired but are otherwise ambivalent about committing to the level of help they really need for their untreated illness.

**Q: What happens if I don't call anyone and make a report?**

A: When impairment is suspected, not making a report prolongs the unac-

ceptable exposure of patients to the risk of unsafe care from the potentially impaired dentist. Failing to act also needlessly jeopardizes the career of a colleague that may easily be saved through therapeutic treatment for the illness. By not making a report, you may open yourself up to the risk of legal action from the Department of Health.

**Q: Are there any possible "impairment" situations in which I cannot fulfill my legal reporting obligation by calling WPHP instead of the DQAC?**

A: Yes, there are two. Any behaviors falling under the definition of sexual misconduct (WAC 246-16-100) cannot be reported to WPHP and stay confidential. These incidents must be directly reported to the Department of Health. In any situation in which there is concern for impairment and there is known patient harm stemming from the suspected impairment, a direct report to the Department of Health is required. In these situations, a report to WPHP is "not a substitute for reporting to the Department."

**Q: In the absence of patient harm, why is the law set up to allow reporting of suspected impairment to WPHP "as a substitute for reporting to the Department" and DQAC?**

A: In order to maximize patient safety, the law is set up to encourage early identification, assessment and treatment of providers who are thought to be impaired. Allowing dentists to self-report to WPHP or to be reported by their employer or colleagues to WPHP rather than to the DQAC serves this purpose. It encourages use of WPHP as a therapeutic alternative to discipline for dentists who need help and can be rehabilitated. Having a chance to avoid the threat of discipline serves as a powerful motivator for such dentists to commit to intensive treatment and an intensive recovery program.

### Commission Staff Contact Information

Department of Health  
P.O. Box 47852  
Olympia, WA 98504-7852

[Trina Castle](#), Executive Director

[Jennifer Santiago](#), Program Manager

[Tracie Drake](#), Assistant Program Manager

[Erin Obenland](#), Case Manager

Customer Service  
360-236-4700

[www.doh.wa.gov](http://www.doh.wa.gov)

[Commission website](#)

### Commission Meeting Dates

Mar. 4, 2016  
Apr. 22, 2016  
Jun. 3, 2016  
Jul. 15, 2016  
Sept. 9, 2016  
Oct. 28, 2016  
Dec. 9, 2016

**Public Health - Always  
Working for a Safer and  
Healthier Washington.**